

TENNESSEE SEX OFFENDER TREATMENT BOARD

POLICY NO. 1

PHILOSOPHY OF SEX OFFENDER TREATMENT

SEX OFFENDING CANNOT BE CURED, ONLY CONTROLLED AT BEST. There is no known treatment that is 100% effective for stopping sex offending. Offenders do recidivate..... they do it again. Treatment is to be stressed as lifelong. Completion of a treatment program does not cure sexual deviance. Long term aftercare is a necessary aspect of community safety and offenders well-being.

THE FOCUS OF THE THERAPY IS ON THE OFFENDER ACCEPTING RESPONSIBILITY FOR THEIR OFFENSE, CYCLE OF ABUSE, AND ALL FACETS OF THEIR LIFE. For the offense, saying "I did it" cannot be considered sufficient by itself; rather, it is knowing the precursors to their offense, the cycle of distorted and deviant sexual thoughts, acknowledging deviant sexuality, acknowledging risk factors for the reoffending such as grooming and control issues, and many other facets of the offense and their life dysfunction. Progress is also shown by the offender acknowledging the positive aspects of their life and gains made in therapy as shown by increased empathy, enhanced self-esteem, beneficial problem solving, and many other adaptive coping and social skills taught within therapeutic structure.

WE ARE VICTIM ADVOCATES, NOT OFFENDER ADVOCATES. No more victims is our motto. Decisions in therapy, hopefully ones which offender will adopt for life, should be based upon preventing further abuse and enhancing community safety.

A COGNITIVE-BEHAVIORAL APPROACH, that includes a relapse prevention focus, strong external supervision, and medication (as indicated) is the designated mode for the treating the sex offender. A cognitive approach is one that addresses dysfunctional core beliefs as well as current thoughts that promote maladaptive behavior. Relapse prevention is a self-control program that provides the offender with a variety of cognitive, behavioral, and social skills training tools for assuming responsibility for their behavior. Essentially, a focus of relapse prevention is learning to identify the factors that increase risk for sexual offending and developing adaptive coping skills for minimizing or eliminating those risks, as well as identifying and escaping lapses to exit from the buildup phase of the deviant cycle before victimization.

DEVIANT SEXUAL ACTING OUT IS PATTERNED, REPETITIVE, PREDATORY, HAS FOCUS ON CONTROL, OFTEN SEEKS TO COMPENSATE FOR OTHER LIFE DEFICITS, IS SECRETIVE, VIOLATES BOUNDARIES, ILLEGAL, AND DEVASTATING TO VICTIMS.

SEX OFFENDING IS A CHOICE; IT IS NOT A DIRECT CONSEQUENCE OF ABUSE OR OTHER FEATURE OF THE OFFENDER'S DEVELOPMENTAL MAKE UP.

COMMUNITY SUPPORT GROUPS ARE NOT APPROPRIATE TREATMENT in lieu of sex offender specific treatment by a mental health professional.

NOTHING "JUST HAPPENS" AS IN THE "IMPULSE RAPE". There is a process to sex offending that is marked by a deviant cycle. Acting out of any sexual abuse has a definable build

up phase that is comprised of deviant sexual arousal, deviant cognitions, decreased empathy, a negative emotional state, and an unwillingness to use other adaptive coping skills and outlets. Other issues, such as low self-esteem, distortions about relationships, unresolved family –of – origin issues, alcohol and drug abuse, childhood abuse, and similar are precursors to the acting out behavior. The offender is viewed as “choosing “to offend regardless of their background and other contributing factors. The offender should be held 100% accountable for their crime.

TRUTH IS NOT ALWAYS APPARENT, but rather more accurately shown by behavior and thought over time that is verified by others. Denial is always present and multifaceted. Denial reveals shame and dishonesty. However, saying “I did do it” doesn’t mean there are no other forms of denial.

HONESTY IS A MUST IN TREATMENT...as the saying goes “You are only as sick as your secrets”. Convicted offenders who are in denial of their offense may benefit from an intensive period of confrontation in a “denial group”. The administration of a polygraph and plethysmograph evaluation will also assist in confrontation. Regardless, convicted offenders who deny should be considered high risk, accorded a stringent level of supervision in the community, and eventually returned to the court authorities if denial persists beyond a reasonable limit. Sex offender treatment is designed for identified abusers who acknowledge their identity as a sex offender.

TREATMENT AND THERAPEUTIC GAINS LARGELY HAPPENS IN STAGES and over extended periods of time. It takes considerable effort by the offender in defining, understanding, and controlling the offense behaviors. Long term control of deviant fantasies and arousal is essential.

OFFENDERS ARE MASTER MANIPULATORS. We need to learn ways to know that the offender is not playing an “act-normal” role, e.g., parroting back to you what you want to hear. Colluding with the offender is partly minimized by using a team approach that involves human services, legal, supervisory, and community support persons.

LESSENERD RISK IS NOT TO NECESSARILY INFER BY PROGRESS IN TREATMENT. We must recognize that offenders are dishonest in many respects with themselves and you no matter how open they are with admitting their offense. Denial, justification, intellectualizing, and minimization are the hallmark qualities of an offender. You and the offender must always be on guard about access to potential victims and re-entry into the deviant cycle.

MANY OFFENDERS WHO OFFENDED WITHIN THE FAMILY ALSO OFFEND OUTSIDE THE FAMILY, AND VICE VERSA. Most offenders have multiple paraphilias. Having offended is a clear sign that one may do it again, albeit in a different way (e.g., exhibitionism) or in victim gender or age. Access to potential victims must be carefully controlled. We must assess for other paraphilias.

OFFENDERS HAVE MORE SIMILARITIES THAN DIFFERENCES, REGARDLESS OF THE VICTIM OR FREQUENCY. Offenders may be defined in many ways, e.g., incest offenders, pedophiles, exhibitionist, statutory rapist, serial rapists and so on. However, the bottom line is that sex offenders act out within a cycle of deviancy and choose to violate the boundaries of other human beings. Because of denial and uncertainty about our ability to really “know the truth” (especially early in treatment), a conservative approach that benefits community safety is best when determining risk, treatment planning, and supervision. With progress and time in

treatment, as well as external verification of treatment progress (e.g., polygraph and report from the community support persons), issues of supervision and treatment can be better defined. Sex offender treatment groups include all types of offenders.

OFFENDERS DON'T FIT STEREOTYPICAL PROFILES. The “trench coat” man or the “popsicle man” is not the average. Sex offending is pervasive and happens within all socioeconomic, ethnic, racial, and religious classes.

MANY OFFENDERS ARE VICTIMS. Victim issues can be a component of treatment but only after the client shows responsibility and management of their abusive behavior.

THERE ARE DEFINITIVE DIFFERENCES IN TREATING SEX OFFENDERS THAN OTHER CLINICAL POPULATIONS.

- 1) Our clients are legally mandated to treatment. We are clearly linked to the legal system. 2) We believe a group approach is the best modality for treatment of an offender. Good sex offender programs are group-oriented, emphasize offender responsibility, recognize the serious nature of risk involved, have a clearly defined means of assessing treatment progress, have a graduated treatment protocol, and emphasize communication with other involved professionals.
- 2) We are often directive and have definitive expectations for our clients. We set treatment goals that are contrary to the offender's wishes.
- 3) We are often confrontative.
- 4) We are prohibitive, e.g., we tell our clients where they can go, who they can see, where they can work, and similar.
- 5) We work with clients who have denial of the problem. We want verification of our client's behavior and may subject them to polygraph evaluations. We doubt self-report, especially in the early phase of treatment.
- 6) We place a high value on the rights and needs of others before the rights and needs of the offender. We are victim and community safety advocates.
- 7) We require waivers of confidentiality in order to facilitate community supervision and communication among involved professionals.

WE BELIEVE THAT OFFENDERS, IN GENERAL:

- 1) Oppose treatment efforts initially. They are not going to like limits. Initial motivation varies and must be cultivated.
- 2) Have an initial poor recognition of problems. Initial insight is often limited and distorted. 3) Act out in many ways that harm others.
- 3) Are initially dishonest to us and themselves.
- 4) Hold secrets and hide themselves from you.
- 5) Will blame others for their problems and see their victimization in terms of their own personal needs, “I was only trying to reach out to her”.
- 6) Will do anything to avoid your scrutiny or involvement in their life. They will try to be your best client.

WE, AS TREATMENT PROVIDERS, ARE PART OF A BIGGER TEAM THAN OUR OFFICE STAFF. By law, sex offender treatment is defined as supervision and therapy. The picture is even bigger when you frame treatment as a public health or community safety issue. Human services, legal staff, community supervisors, therapist, medical staff, supportive friends or family members, ministers, and similar persons should be included as a part of the team

approach. When we think we can do it all for the offender and make judgment of risk without consultation and appraisal, then we are likely increasing, rather than decreasing, community risk.

IT TAKES SPECIALIZED SKILLS TO MONITOR A SEX OFFENDER IN THE COMMUNITY.

It is important to develop a wide continuum of supervision strategies that will assist the community supervisor in monitoring the offender, as well as increasing protective factors that will aid in the offender's adjustment in the community.

WE HAVE TERMS AND PROCEDURES you must learn in order to converse within the sex offender field. These terms include approaches used in clinical treatment, as well as terms and procedures used by DCS, the legal system, and community supervisors.

ISSUES OF REUNIFICATION AND VICTIM-RELATED ISSUES REQUIRE A CAREFUL DECISION PROCESS. procedures and supervision. Reducing further victimization is a primary goal of offender treatment and any victim contact process. Adequate safeguards to promote the emotional and physical protection of the victim(s), and other vulnerable children or adults, is a necessity at all stages of reunification.

WE NEED TO KNOW OUR OWN VULNERABILITIES. We need personal boundaries in dealing with offenders. We need to know our biases in working with this population. We need to acknowledge that working with offenders may not be the best thing for us in respect to our past history (e.g., past abuse). If boundaries blur between therapist and offender, then we lose the therapeutic objectivity we need to be effective counselors. A personal relationship with abusers is not condoned by the board. Working with offenders requires firm therapeutic boundaries. We must be able to confront and direct offenders into adaptive ways of coping with their deviancy. Equally, we must be able to maintain a working alliance with the offender. It is often times a "difficult connection" to maintain as we equally withhold trust, respect without colluding, and encourage our clients.

IF YOU ARE NOT COMPETENT by training and experience....don't do it. Be willing to seek out help and clarifications from your peers, or consult with clinical members of the Tennessee Sex Offender treatment Board.

WE ABIDE SPECIFICALLY BY THE ETHICAL GUIDELINES OF THE ASSOCIATION FOR THE TREATMENT OF SEXUAL ABUSERS AND THE RULES OF THE TENNESSEE SEX OFFENDER TREATMENT BOARD. We honor other state and professional practice ethical guidelines that promote the mental health treatment of individuals. We encourage professionals to always be cognizant of their professional limitations and boundaries.

VICARIOUS TRAUMA AND BURN OUT ARE FEATURES OF OUR WORK. Sometimes the abuse stories that we hear impact us emotionally. Work with offenders is stressful. If we are not occasionally emotionally stressed by what we hear or by the work we do in sex offender therapy, then perhaps we are far too distant from the issues that need our therapeutic attention. However, it is important for us to rationally detach from our job when we leave the workplace. Therapist support and on-going plans for dealing with the obviously distressing aspects of our work is necessary for maintaining our health.